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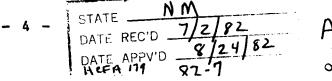
June 28, 1982 and feasibility of using more economical alternative facilities and services.

- E. Specific Services which are Skilled Nursing -- Skilled nursing services include but are not limited to the following:
 - 1. Intravenous or intramuscular injections and intravenous feeding. (Injections which can usually be selfadministered -- e.g., the well-regulated diabetic who receives a daily insulin injection -- does not require skilled services.)
 - 2. Levine tube and gastrostomy feedings.
 - 3. Naso-Pharyngeal and tracheotomy aspiration.
 - 4. Insertion or replacement of catheters and sterile irrigations of catheters.

INTERMEDIATE LEVEL OF CARE

Services Which Are Not Skilled Nursing (statements contained herein are not intended to negate the Nurse Practice Act but rather are used only in the context of differentiating between Skilled and Intermediate level of care.)

- A. Importance of Service to the Patient -- The importance of a particular service to an individual patient does not necessarily make it a skilled service, e.g., a primary need for a nonambulatory patient may be frequent changes of position to avoid development of decubitus ulcers. Since changing of position can ordinarily be accomplished by unlicensed personnel, it would not be a skilled service.
- B. Specific Services Which Are Supportive or Unskilled -- Supportive services include but are not limited to the following:
 - 1. Administration of routine oral medications, eye drops, and ointments.
 - 2. General maintenance care of colostomy or ileostomy.
 - 3. Routine services in connection with indwelling bladder catheters. (This would include emptying containers and cleaning them, clamping tubing, and refilling irrigation containers with solution.)
 - 4. Changes of dressings for noninfected postoperative or chronic conditions.
 - 5. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of



minor skin problems.

- 6. General methods of treating incontinence, including use of diapers and rubber sheets.
- 7. General maintenance care in connection with a plaster cast.
- 8. Routine care in connection with braces and similar devices.
- 9. Use of heat for palliative and comfort purposes.
- 10. Administration of medical gases after initial phases of teaching the patient to institute therapy.
- 11. General supervision of exercises which have been taught to the patient.
- 12. Assistance in dressing, eating, and going to the toilet.

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Dressings

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vided only under direction of a licensed nurse.	mucus removal) for continuing care which can be pro-	tric sunction (for	removal, trache-	centesis, there-	for spinal puncture, para-	quired such as sterile settups	services re-
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= Specialized Other special Therapists Qualified Procedures by Rehabilitative

The scope of these specialized services patient to the care. supervision & care by professional personnel as well as direct observation, nursing time of ancillary nursing reflect the scope & response of the (comprehensive care) may require maximum Detailed documentation must Patlent's

condition may be:

existing illness. An acute episode of an already

Nature of the illness may require

care may be necessary to sustain where the patient is totally dependent. Comprehensive nursing Cerebral or spinal cord pathology

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patient.

needs of the totally dpendent unlimited time to meet all of the the most comprehensive care for

drainage, etc., require complex & sterile technique changes more which, due to location, copious Dressings for deep lesions or wounds frequently than once a day.

RN or LPN at performance. active treatment & requires presence of aspects of skilled nursing, part of Includes related teaching & adaptive

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Restorative Care

post-hospitalization speech therapy &/or criterion, per se, does not qualify for Not applicable.

audiology, physical therapy, occupational therapy, etc. This

Initial or immediate

skilled nursing level.

cleaning, Dressings for areas requiring & sterile technique. irrigation, medication

range of motion exercise (activo & passive) &/or proper Requires some assistance with positioning of patients.

maintain level of motion & exercises to Independent range of restoration.

Not applicable

aldes, clastic stockwhen prescribed. ings or Ace bandage, Application of band

Not applicable.

Not applicable.

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FLUID INTAKE & OUTPUT			NUTRITION (Regular and Therapeutic)	HOBILITY & TRANSFER	FERDING	
Adjustment of medication may be required, due to fluid retention, according to physician's orders.		This criterion does not, per se, warrant skilled nursing level.	Nutritional value requirements of diet may need to be calculated & adequate replacement made for food refused from planned meal patterns.	Patient unable to ambulate or transfer without trained assistance.	 a. Chokes eastly 6/or aspirates. b. Needs levine 6/or gastrotomy tube feeding on a sustained basis. c. Tendency twoards regurgitation 6/or potential danger. 	
Measuring of urinary intake & output may be ordered by physician. Documentation of assessment to reflect signs of fluid retention such as peds edema, etc., with notification to physician.		This criterion does not, per so, warrant ICF mursing level.	Nutritional value requirements of diet may need to be calculated a adequate replacement made for food refused from planned maal patterns.	Patient requires assistance from attendant to get from bed to chair, wheelchair, bathroom or dining room.	Hand feeding may be required due to physical or mental conditon, however, not merely because of blindness, slowness or awkwardness. Patient should evidence (a) Weakness 6/or fatigue (b) Hajor paralysis; major deformity of hands, (c) prolonged psychological reasons, (d) minor difficulty in swallowing. Patient may need self help device	
Resident may need encouragement or assistance to drink adequate water.	May need therapeutic diet for control of existing organic conditon.	modification of regular diet (example: meat ground or vegetables mashed).	May be unable to manage own food & requirements. May need texture	Fully ambulatory or semi-ambulatory (necensary assistance & guidance provided).	Resident may need supervision to eat & some assistance in eating (some foods may need to be cut, bread buttered, milk carton opened, etc.). Absistance & encouragement eat may be necessary due to (a) Tremore; minor residual paralysis; some deformity of hands, (b) to eat.	- :

	BEHAVIOR & MENTAL STATUS	B. Cathether Care	(4) Post-Surgt- cal	(2) Bladder Tumor (new growth) or other organic conditions (3) Hypertro- phied Prostate.	(1) Neurogenic Bladder	BLADDER & BOWEL RETAINING A. Bowol &/or bladder continence based on:			BOWEL AND BLADDER	
Comatose & requiring nasogastric refeedings or intravenous therapy	Behavior may be labile requiring 24 hour a day availability of professional judgment. A physical condition may be present in a totally dependent individual who would be unable to communicate recurring problems & needs requiring professional evaluation. May require frequent IM or IV medications for additional control.	Cathether care with complications (bleeding, urinary tract infections, medicated irrigations, etc.).				Specific bladder & bowel retraining may be required. Assessment & initiation of bladder &/or bowel retraining plan.		Chronic incontinence with skin breakdown which requires frequent perinesi care.	May require procedures due to complications which require professional involvement.	
Not Applicable.	Automatic Physician Reviewer Referral.	Due to physical condition patient requires assistance with regular catheter care.				Facility is evaluating resident's potential for retraining program OR resident is in a specific program.	Some perineal care required.	Chronic incontinence; needs to be taken to bathroom routinely or needs use of bed pan, urinal, or commode.	May require assistance with elimination of a regular & recurrent basis.	-
Not Applicable.	Presence of behavior problems which can be managed by using commo sense, respect 6 guidance.	Routine cathether self care.				Not applicable.		occassional incontinence.	Includes bollet routing to encourage continence. Needs reminding to prevent	

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Conditions involving multiple complications requiring skilled management of an aggregate of services.		. Mental Retardation (Limited to ICF (MR) Facilities only)	are met. However, Patient is in a Dis- charge Status as du- fined by NNPSRO. Review Coordinator may certify.	2. Physician Reviewer approves.	3. Physician Reviewer denies.	tratively denied be- cause level of care request is not a Medicare/Medicaid program benefit. Review Coordinator may deny request for review.
Pattent's condition requires daily, regular trained observation, close supervision, treatment plan management and monitoring by RN or LPN for multiple complications, the relationship and effect of which necessitate ensuring the pattent's recovery and/or medical safety.	Non-physician reviewer must apply this criterion only to those cases in which there is a high <u>probability</u> , as opposed to a <u>possibility</u> , that complications	Except in unusual medical necessity cases, mental retardation would not qualify a patient for this level. Patient would normally meet other criteria.	Not applicable.	Rationale must be given and documented on review worksheet.	Rationale must be given and documented on review worksheet.	
Not applicable.			NMPSRO requires documented charting of placement progress, availability of appropriate placement, etc., in order to recertify on this basis.	Rationale must be given and documented on review worksheet.	Rationale must be given and documented on review worksheet.	•
Not applicable.			Nut applicable.	Not applicable.	Not applicable.	

B. Admission Review

Before authorization for payment, a review of each applicant's or recipient's need for admission must be accomplished. This will be done through submission of a long term care abstract to the NMPSRO for review.

1. SNF Admission

The attending physician must make a medical evaluation of the recipient's need for SNF care, and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical findings, mental and physical functional capacity, and prognosis. After the evaluation is made the attending physician must establish a written plan of care that includes:

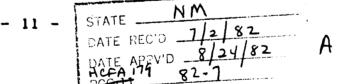
- Diagnosis, symptoms and complaints
- Description of functional level
- Objectives
- Any ordrs for medications, treatments restorative or rehab services, diet, and special procedures
- Plans for continuing care
- Plans for discharge

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review. The NMPSRO will make a level of care determination and assign an initial continued stay review date will. The initial continued stay review date will in most instances be 30 days. The Review Coordinator may assign a length of stay shorter than 30 days based on the recipients needs and stability of conditions. Under no circumstances, will the initial period exceed 30 days.

2. ICF Admission

The attending physician must make an evaluation of the recipient's need for ICF care and certify such need on the abstract. This evaluation must include diagnosis, summary of present medical and social findings, mental and physical functioning, prognoses, and kind of services needed. After the evaluation is made the attending physician must establish a written plan of care that includes:

- diagnosis, symptoms, complaints
- functional level description
- objectives
- any orders for medications, treatments,
 restorative and rehab services, activities,
 therapies, social services, diet, special



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procedures, plans for continuing care, and plans for discharge.

The above required information will be condensed onto the abstract and forwarded to the NMPSRO for review.

The NMPSRO will make a level of care determination and assign an initial continued stay review date. The initial continued stay review date will in most instances be 90 days. The Review Coordinator may assign a length of stay shorter than 90 days based on the recipient's needs and stability of condition. Under no circumstances will the initial period exceed 90 days.

3. ICF/MR Admission

The same as set forth above for ICF admissions will apply with the following addition. An interdisciplinary team of health professionals must make a comprehensive medical, social, and psychological evaluation of the recipient's need for admission to the ICF/MR. This evaluation will include diagnoses, summary of present medical, social and developmental findings, medical and social family history, mental and physical functional capacity, prognoses, kinds of services needed, evaluation of resources available in the home, family and community, and a recommendation concerning the need for admission to the ICF/MR.

C. Continued Stay Review

Continued stay review will be accomplished through the submission of an abstract to the NMPSRO for review and/or through on-site review.

Using the level of care criteria described in this plan, the reviewer will review the abstract and make a determination as to the continued need for level of care and assign a recertification date for review.

1. SNF

In most instraces the reviewer will assign a continued stay review date of 90 days. The reviewer has the option of assigning a period of less than 90 days, based on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 90 days.

2. ICF

In most instances the reviewer will assign a continued

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stay review date of 6 months. The reviewer has the option of assigning a period less than 6 months, based on the recipient's medical needs and stability of condition. Under no circumstances will the continued stay review date exceed 6 months.

3. ICF/MR

Same as above for ICF.

4. Change in Level of Care

When it has become apparent that a recipient's condition and needs have changed sufficiently to warrant a different level of care, it is the responsibility of the physician and the facility to submit an abstract reflecting these changes so that a new level of care determination can be made.

D. Abstract & Forms

Attached is a copy of the abstract and other forms to be used in carrying out long term cre review. Instructions for completion of the abstract can be found in the accompanying manual.

E. Appeals

Should the NMPSRO, through carrying out this plan, render an adverse decision regarding admission, level of care, or length of stay, the following appeal procedure is available.

Any resident, admitting/attending physician or provider of services who is dissatisfied with an adverse review determination of the NMPSRO may request a reconsideration of such determination by the NMPSRO LTC Subcommittee. After the procedures for the reconsideration (contained in the manual) are carried out, should the appealing party still be disatisfied with the NMPSRO reconsideration determination, the appealing party may then avail themselves of the State Fair Hearing Process.

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